

Final Report

Office of the Medical Inspector

Firearm Access And Automobile Driving Among Veterans with Dementia

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Executive Summary

Following a tragic event when an elderly veteran shot a physician and the VAMC police then shot and killed the veteran, the Office of the Medical Inspector (OMI) became concerned about several issues. The safety of patients and staff was foremost, but the possible relationship between dementia in older veterans and the possession of firearms, as well as between patients with dementia and their automobile driving behavior was of concern. With the assistance of the Geriatrics and Extended Care Strategic Healthcare Group (G/EC SHG), a quality improvement project was developed for the purpose of assessing the topic of early dementia, firearm and driving safety.

Two products were developed for this quality assessment project: (1) a questionnaire on firearms in the home and on driving status, and (2) a preventive/educational informational intervention, or “anticipatory guidance,” for targeted patients and their families. The final set of materials, including the Firearms and Driving Questionnaire, Firearms and Dementia Pamphlet, Driving and Dementia Pamphlet, and Guidelines to Providers, was given to 10 Dementia and 15 Geriatric Evaluation and Management (GEM) clinics in 21 states throughout VHA; these sites were chosen to be reasonably representative of large and small clinics and diverse geographic regions. Sites were instructed to use the questionnaire with patients who had previously been diagnosed with mild to moderate dementia and had a recent cognitive status score to indicate severity of dementia. A total of 338 patient questionnaires were returned. The Mini-Mental State Examination (MMSE, Folstein et al., 1975) was the most frequently used cognitive status score in this sample and was reported for 307 of the total 338 patients in the sample. The results of the questionnaire on firearms in the home and on driving status were correlated with MMSE scores for those 307 patients.

Conclusions

1. This information gathered from the questionnaire (40% of the dementia patients in the survey had a firearm in the home, and 44% drove automobiles) can be important in the clinical care of patients with dementia.
2. The project materials (questionnaire, pamphlets, and guidelines to providers) were found by the users to be relevant, easy to use, and of value in working with patients/families.
3. Restriction of driving or of firearm possession involves what some consider basic rights, and thus carries a serious ethical obligation on the part of the clinician who recommends such limitations. However, there is an equally serious obligation for clinicians to recommend such restrictions when the patient is known to have cognitive limitations that pose a significant risk when in the possession of a gun or when driving a motor vehicle.
4. Determination of reliable rates of driving and firearm possession among populations of compromised patients requires further carefully structured surveys that include a well-defined denominator population.

Recommendations

1. VHA should disseminate this report widely, to increase awareness of these potential safety issues.

2. The work group products, including questionnaire, informational pamphlets, and guidelines for providers, should be made available for interested sites to pursue further quality improvement and research activity on these topics. Potential mechanisms include posting the materials on the G/EC SHG web site. The appropriate VHA Program Office could also make electronic versions of the materials available on disc median for local production upon request.
3. The informational pamphlets produced by the work group should be available to patients/families through the appropriate clinic setting after the dementia assessment has been completed. Limited numbers of pamphlets could also be made available in other outpatient settings as appropriate by the VAMC.
4. VAMCs should ascertain the rules with respect to dementia, driving and firearm ownership in the states where they are located and provide guidance on these topics to their practitioners.
5. Due to the limited amount of research available on dementia and firearms and dementia and driving, appropriate VHA offices should encourage further investigation of these issues, including formal research. For example, the Office of Patient Care Services could collaborate with relevant VA centers such as Geriatric Research, Education and Clinical Centers (GRECCs), Mental Illness Research, Education and Clinical Centers (MIRECCs), Parkinson's Disease Research, Education and Clinical Centers (PADRECCs), Health Service Research & Development (HSR&D) Centers, or Patient Safety Centers of Inquiry.
6. Further investigation of firearm and driving safety could include examination of different outpatient settings, such as home-based care; or different at-risk populations, such as psychiatric.
7. As part of good clinical practice, VHA should strongly encourage the assessment and appropriate counseling regarding driving practices and availability of firearms in the assessment/management of patients with dementia. The assessment of these issues can be conducted via an interview or with a formal questionnaire.

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I. Introduction and Background

A tragic event occurred at a VA Medical Center (VAMC) when an elderly veteran shot a physician and the VAMC police then shot and killed the veteran (see Attachment A). The Office of the Medical Inspector (OMI) became concerned about the safety of patients and staff. Issues of special concern were the safety of firearms possession and automobile driving in older veterans with dementia.

Assessment of firearm possession may also permit medical practitioners to prevent some suicides, inasmuch as the overall most common method of suicide is by use of a firearm. The group with the highest risk for suicide is older white men (Hoyert et al., 1999). Further, over 90% of elderly patients who commit suicide have a mental illness (Conwell, 1992). It is therefore of considerable clinical interest to better understand the availability and safe storage of firearms in the homes of veterans, especially those with depression, other mental illnesses, or dementia. In a recent small sample of older primary care patients, 27.9 % of older persons reported having some type of firearm in the home and 19.7 % reported having a handgun in the home (Oslin et al., 2003). Patients with suicidal ideation, cognitive impairment, or high levels of depression were as likely to have a firearm available as patients without these symptoms. The authors concluded that asking about firearm availability and safety practices should be part of routine clinical practice for older adults with behavioral health problems.

The OMI and the Geriatrics & Extended Care Strategic Healthcare Group (G/EC SHG) of the Office of Patient Care Services (PCS), together with consultants from several VAMCs, formed a Dementia Safety Work Group to assess the relationship in older veterans of dementia to the possession of firearms and to driving behavior. The work group developed two tools for this quality assessment project: (1) a questionnaire on firearms in the home and on driving status, and (2) a preventive/educational informational intervention, or “anticipatory guidance,” for targeted patients and their families.

II. Methods

A. Case review

The OMI reviewed medical records and reports related to the veteran involved in the gunshot episode noted above.

B. Work Group composition and decisions

The work group was composed of staff from VA Central Office (OMI and G/EC SHG), and appropriate experts from VHA facilities. The work group met via conference call approximately 15 times over a 25-month period between March 2001 and March 2003, plus one face-to-face, two-day meeting in Washington, DC, June 13-14, 2002. The group decided to assess the relationship between cognitive impairment and the presence of firearms in the home, and between cognitive impairment and veterans’ driving status. In

addition, the group developed brochures on these topics to be used as an educational intervention for patients and their families.

C. Development of materials

1. Questionnaire

The work group adapted a questionnaire that had been used in a previous primary care study of firearm availability (Oslin et al., 2003). This final Firearms and Driving Questionnaire (see Attachment B) included questions about the availability of a firearm (rifle, shotgun or handgun) in the home, whether the firearm is stored unloaded and/or unlocked, and whether there is ammunition available for the weapon. The driving portion of the questionnaire focused on aspects of dementia important to driving safety as well as on family perceptions of the driver's competence; the items chosen were based on a review of the current literature.

The questionnaire was first pilot-tested at seven sites, including 5 dementia clinics and 2 Geriatric Evaluation and Management (GEM) clinics. Feedback from staff was generally positive about the importance of the topics addressed and the relative ease of use of the questionnaire. Specific suggestions for changes in the questionnaire were incorporated into the instrument.

2. Informational material

The work group was unable to find existing patient education materials on firearm safety and so a Firearms and Dementia Pamphlet was developed. (see Attachment C). This pamphlet focused specifically on recommendations for firearm safety in a home where someone with dementia resides.

The work group also developed a Driving and Dementia Pamphlet (see Attachment D) as a resource for drivers with dementia and their families and friends. The content was chosen after a review of the current literature and other informational brochures; the Hartford Financial Services Group provided a key resource, particularly its publication, *"At the Crossroads: A Guide to Alzheimer's Disease, Dementia and Driving."* (The Hartford, 2000).

The work group then developed a two-page Guideline for Providers Pamphlet (see Attachment E) to indicate the minimum appropriate response of the provider when information of potentially unsafe conditions was identified on the Firearms and Driving Questionnaire. This guideline was developed after consideration of several factors: 1) the need to be more general than specific because of legal issues in individual states; 2) the fact that providers have a responsibility to respond appropriately when information indicating a potentially hazardous situation is obtained; and 3) the wide range in individual clinician's familiarity with VHA rules, regulations, policies, and procedures. The guideline discusses: 1) the general overall direction of response; 2) situations where there is a need for immediate action; 3) the need for further risk assessment; 4) issues

regarding patient privacy; 5) referral and other resources; 6) reporting requirements; and 7) appropriate documentation.

The group also developed a Feedback Form (see Attachment F) to obtain information from the several sites on their experience with the project materials. The feedback form included questions on how sites administered the materials, as well as 5-point Likert scales on which staff rated the ease, relevance, value, and accuracy of the materials, as well as, whether enough information was collected or provided. There were also open-ended questions for staff to provide narrative comments and suggestions.

D. Distribution of materials

The final set of materials, including the Firearms and Driving Questionnaire, Firearms and Dementia Pamphlet, Driving and Dementia Pamphlet, and Guidelines to Providers, was given to 10 Dementia and 15 GEM clinics in 21 states throughout the VHA in late summer 2002; these sites were chosen to be reasonably representative of large and small clinics and diverse geographic regions. Sites were instructed to use the questionnaire with patients who had previously been diagnosed with mild to moderate dementia and had a recent cognitive status score to indicate severity of dementia.

E. Mini-Mental state examination

The Mini-Mental State Examination (MMSE, Folstein et al., 1975) was the most frequently used cognitive status score in the sample. On this assessment, 30 is a perfect score while scores below 24 are typically considered abnormal, although advanced age and low education are associated with lower scores in the absence of a neurologic disorder (Crum et al., 1993). We categorized the MMSE scores as follows: 25-30 = normal, 20-24 = mild impairment, 13-19 = moderate impairment and 0-12 = severe impairment.

F. Analyses

The results of the questionnaire on firearms in the home and on driving status were correlated with MMSE scores for those patients for whom a MMSE score was reported. Analyses of the returned questionnaires included a summary of patient demographics, and analysis of the Feedback Form results.

III. Results

A. Case review

Although the medical record of the veteran involved in the shooting incident did not show a prior history of mental illness or a diagnosis of dementia, the family did report a recent change in behavior. This behavior change combined with the brain changes found at autopsy (see below) raised the possibility of an unrecognized cognitive decline.

The local police department and the FBI conducted investigations of the incident and the State Medical Examiner's office conducted an autopsy. The conclusions from these reports showed that:

1. Prior to being transported to the medical center, the veteran was not properly searched by the sheriff's deputy.
2. The veteran's medical records revealed no evidence of previous mental health issues.
3. The Medical Examiner's office noted that the cause of the veteran's death was a gunshot wound to the head.
4. Gross anatomic examination revealed that the veteran suffered from severe coronary artery atherosclerosis as well as cardiomegaly with left ventricular hypertrophy and myocardial fibrosis. Pulmonary emphysematous changes and prostatic adenocarcinoma were significant but incidental findings. There was no ethanol in the blood. No other toxicology studies were done.
5. There were no brain metastases. However, microscopic examination of the brain showed that there were neurofibrillary tangles consistent with a degenerative neurological process associated with a progressive decline in cognition (Bennet & Plum, 1996).
6. Investigations conducted by the local police, and the FBI supported the actions taken by the medical center police.

B. Questionnaire results

1. Overall results. By mid-November 2002 we had received completed questionnaires on 338 patients from 15 of the total 25 clinics; this represented 13 sites, as some sites had more than one clinic; MMSE scores were reported on 307 of these patients. Seventeen clinics from 15 sites returned the Feedback Form. The 31 patients who completed the questionnaire but did not have a MMSE were not included in our analysis.

The average age of the participants was 78 years. The average MMSE score of the respondents was 21.2, which indicates mild cognitive impairment. The range, however, was quite wide (8 to 30).

2. Firearms. There were 307 respondents who had a measured MMSE, and 122 of them (40%) reported firearms in the home. Respondents with access to firearms had an average MMSE score of 22.3, which is not significantly different from the score of 20.4 for patients without access to firearms. Of the 122 respondents with firearms at home, 31 or (25%) of them had an MMSE score of 19 or below, consistent with moderate to severe cognitive impairment.

Of the 122 respondents reporting firearms in the home that answered the questions:

- 32% (39) had only a handgun(s)
- 43% (52) had only another type of gun(s)
- 25% (31) had both a handgun(s) and another type of gun(s)
- 77% (94) had ammunition available for the firearm

- 73% (88) reported their guns were stored unloaded
- 21% (25) reported their guns were stored loaded
- 6% (7) did not know the loading status
- 61% (74) stated that their guns were unlocked
- 36% (44) stated that their guns were locked
- 3% (3) did not know the locked/unlocked status
- 15% (18) stated that firearms in their homes were both loaded and unlocked
- 4% (5) of those that had guns (1% of the survey respondents) had moderate to severe cognitive impairment and had guns that were both loaded and unlocked in their homes

(See comparison Tables in Attachment G)

3. Driving. Of the 307 respondents with a measured MMSE, 136, (44%) drove automobiles. The respondents who drove had an average MMSE of 23.8, compared with an MMSE of 19.1 for the 171 who did not drive. This is a clinically significant difference, as the non-drivers had an average score at or below the cutoff of 19 that represents moderate to severe cognitive impairment. Of the 136 drivers, 22 (16%) had MMSE scores 19 or below, consistent with moderate to severe cognitive impairment. Forty-four percent of the non-drivers had a score of 19 or below.

Of the 136 respondents who drove:

- 81% (110) answered that they drove alone (one respondent said he did not drive, but he also answered that he drove alone)
- 12% (16) reported having gotten lost on familiar routes
- 15% (20) had difficulty in making decisions in traffic
- 7% (9) were involved in motor vehicle accidents
- 31% (42) stated that others had expressed concerns about their driving.
- 15% (20) said they had been advised to stop driving

(See comparison Tables in Attachment G.)

C. General comments from those who administered the questionnaire

Most clinics (11/17; 65%) gave the questionnaire to both patient and caregiver. On a scale of 1 (low) to 5 (high), the most frequent (modal) responses by clinicians regarding the ease of use, relevancy, sufficiency of information collected, and value to providers in their work with veterans and families were 5, 4, 3, and 5, respectively. Comments about the questionnaire were positive (e.g., “The questionnaire was unexpectedly useful.” “Very good. Helps initiate the conversation with the patient and family about safety issues.”) Most clinics noted no problems in administering the questionnaire. A few made suggestions regarding additional information they would like to collect or minor changes in format.

D. Comments on the Firearms and Dementia Pamphlet

The Firearm and Dementia Pamphlet was used at all of the sites and received mostly positive feedback from the providers. Most clinics (10/17; 59%) gave the Firearms and Dementia Pamphlet only to patients/caregivers who indicated on the questionnaire that there was a gun in the home. On a scale of 1 (low) to 5 (high), the modal responses regarding relevance, accuracy, sufficiency of information provided, and value to providers in their work with veterans and families, were 5, 4, 4, and 5, respectively.

Comments on the pamphlet were positive overall (e.g., “Very well done. These are important topics for this population and their care providers.” “I was unpleasantly surprised to learn how many demented patients have guns in their homes. As a result of participation in this project, I am more likely to routinely ask about guns and counsel about gun safety.” “Agree asking of firearms should be a routine question.”).

E. Comments on the Driving and Dementia Pamphlet

The Driving and Dementia Pamphlet was used at all of the sites and received mostly positive feedback from the providers. Most clinics (12/17; 71%) gave the Driving and Dementia Pamphlet only to patients/caregivers who indicated on the questionnaire that the patient still drives. Some clinics (4/17; 24%) gave the pamphlet to all patients/caregivers who completed the questionnaire.

Comments on the pamphlet were, again, positive overall:

- “Excellent pamphlet on a difficult topic.”
- “It helped me improve the driving questions I ask during the interview. I am more likely to refer patients for driver’s evaluation or education.”
- “Good, well received. Very clear and relevant. Good for take home. Helpful in dealing with a very relevant issue.”
- “Valuable for distributing to persons who are to be reported to public health with diagnosis of dementia. Reinforces the fact that driving is a complex task and provides rationale for the person with dementia being a high risk driver.”
- “We report diagnosis of dementia to DMV. Even though we explain we are mandated and we’re not responsible for taking away driving licenses, most patients were not ready to accept safety issues and driving risks. Having this pamphlet emphasized the need to face this and a list of provided warning signs.”

A few made suggestions on other information to provide or minor changes in format. One respondent suggested that, while driving is an important issue, it is only one of many topics that should be considered early in discussions. One also recommended that it be made clear that only some medical centers have staff available to evaluate an older driver’s skills and that if such testing is completed in the community, VHA will not cover its cost.

F. Comments on the Guideline to Clinicians

On a scale of 1 (low) to 5 (high), the modal response regarding the relevance, accuracy, sufficiency of information provided in the Guideline for Providers, and value to providers in their work with veterans and families was 4.

There was a range of comments on the Guideline for Providers. Positive comments included noting its utility for addressing all patients with any degree of cognitive impairment, as well as for addressing the importance of this topic and the need for further development. Suggestions for revision of the “Guideline” included addition of an introductory section providing some background information and a purpose statement, a more specific definition of “driving problems” and “possession of a gun”, and deleting some of the headings. It was noted that the “issues of confidentiality” section was redundant. Greater specificity of what constitutes a driving problem, such as getting lost, crashes, moving violations, or near misses, was thought to be appropriate.

More general comments suggested that the information should be presented in a form other than as a “guideline”, and that dissemination of this information into busy primary care practices is a challenge. It was noted that reporting issues are problematic, ranging from the propriety of releasing information when reporting is not mandatory to the question of the criteria to be used for determining who should be reported.

G. Limitations of the Project

This was a pilot quality improvement project, and the findings should be viewed as preliminary. The main purpose was to investigate the extent of firearm access and driving among a sample of outpatients with dementia, and to explore the feasibility of using a short questionnaire and educational pamphlets with this population. Large and small dementia and GEM clinics from diverse geographic regions were selected to participate, although clinic sampling was not random in VHA as a whole. In addition, sampling of participants within clinics was neither random nor uniform across sites. The study did not have a defined denominator population from which to compute response rates. Further, the data were collected by self-report, did not include information from patients attending other clinics, and did not include refusal rates. Although the findings cannot be generalized to the whole population of veterans with dementia seen in VHA dementia or GEM clinics, the results do give a general sense of the magnitude of firearm and vehicle access within this 307-person sample and the feasibility of using the materials with this group.

IV. Discussion

A. Dementia and Firearms

The percentage of homes in this analysis in which there was a firearm (39%) is consistent with previous national data on the percentage of households with at least one firearm (40%) (Azrael, 2001). There was a large geographic variation that ranges from 15% to

20% in the Northeast to about 60% in the South (Alabama, Louisiana, and Mississippi) (Azrael, 2001). Thus, patients with dementia would seem to have firearms at home no more often than the rest of the population in general.

The dangers of firearm possession for patients with dementia has been previously noted at another VAMC (Mendez, 1996); in addition to the case report there was an accompanying editorial (Green, et al., 1996). The only prior survey that related firearm presence in the home with dementia showed that firearms were present in 60% of homes of patients with dementia, a percentage consistent with the geographic location of the study (Spangenberg, 1999). This study also found that these firearms were loaded slightly more often (44%) than we found (21%)

The presence of a firearm in the home has been shown to be associated with an increased risk of suicide. A case-control study found that a handgun in the home is a risk factor for suicide in mid- to late life (Conwell et al., 2002). Conwell also found that an unlocked gun or a loaded gun was associated with an increased risk of suicide. While this probably also applies to non-lethal injury to self or injury to others, whether lethal or not, the only data on this point are anecdotal (Mendez, 1996).

An important consideration in assessing the potential risks of having a firearm available is the safe storage of the gun. If firearms are to be kept in the homes of patients with cognitive deficiencies, it is highly recommended that the firearms be stored unloaded and locked with either a trigger lock or in a locked cabinet. Of course, removing the firearm from the home is also an option that will reduce the risk of an accident or suicide. It appears that the clinicians' responsibility in this area is unclear as are the criteria for any intervention (Green, 1996), other than general advice and material such as the brochure used in the current assessment.

The work group judged that the findings support concern regarding firearm-related safety issues in patients seen in dementia and GEM clinics in VHA. Many of the providers remarked that the questionnaire raised an important but often overlooked clinical problem. Both the results of the questionnaire and the comments from providers point out that firearm availability is higher than generally thought. This knowledge can be important in the clinical care of patients with dementia.

B. Dementia and Driving

Our survey indicates that some veterans who attend dementia or GEM clinics in VHA facilities continue to drive despite cognitive impairment. Almost one-third of those who continued to drive reported that others had expressed concerns about their driving, and 15% noted they had been advised to stop driving.

Demographic trends indicate that the number of older licensed drivers will increase dramatically in the coming years, as will the prevalence of age-associated illnesses such as Alzheimer's disease (AD) and other dementias. Published data indicate that, compared to the general middle-aged driving population, older drivers with dementia are at an increased risk of accidents (Rizzo et al., 1997; Tuokko et al., 1995; Dubinsky, et al.

2000). In one small series, 41% of patients attending a dementia clinic either had had an automobile accident or had likely caused one (Lucas-Blaustein et al., 1988). Even when accidents are not taken into account, driving performance is affected by AD and other cognitive impairments (Wild, et al., 2003). These patients are at risk for becoming lost in familiar areas, driving in the wrong direction, driving at inappropriate speeds, failing to follow directional signs, and cutting across center lines (Bloedow and Adler, 1992; Kazniak, Keyl, and Albert, 1991; Cox et al., 1998). While many patients with dementia, including veterans, do stop driving after the onset of symptoms of dementia, an unexpectedly large number continue to drive (Logsdon, et al., 1992; Dobbs, 1997; Foley, et al., 2000; Adler, et al., 2003). Because it is common for persons with dementia to continue to drive after disease onset, and increasing numbers of such persons are expected, it is not surprising that there is an increased concern about older drivers.

Solutions to this problem are not easy. Driving is a lifeline for many older persons, including those with cognitive impairment. Still, the social structure may provide adequate support for those who do stop driving voluntarily (Taylor, et al., 2001). Nevertheless, neither the public nor the patient with dementia should be put at risk because of the patient's impairment. One example is the recent tragedy in Santa Monica, CA when an older driver caused multiple deaths in a group of pedestrians (Editorial, New York Times, July 27, 2003). Unfortunately, the MMSE and similar tests, while useful as brief cognitive status assessments, are not diagnostic screening tests for dementia and are not good predictors of driving ability when the cognitive deficiency is only mild to moderate (Dobbs, et al., 2002; Withaar, et al., 2000). Some do recommend that anyone with an MMSE score less than 18 should stop driving altogether (Kubetin, 2003). An actual road test is probably the best standard to use (Hunt, et al., 1993) but is often difficult to arrange.

From a regulatory viewpoint, the strictest approach would be to remove the driver's license of anyone who has moderate to severe cognitive impairment or who fails a road test. This is mandatory in only a few jurisdictions (see web site www.nhtsa.dot.gov/people/injury/olddrive/FamilyFriends/state.htm for a summary of the current rules by state) and has been implemented in California since 1988 (Reuben, et al., 1996; Cable, et al., 2000); nevertheless, this policy did not prevent the Santa Monica incident noted above. Unfortunately, removal of a license to drive does not necessarily mean that the person does not drive.

When the regulatory option is not available, discussion and planning with the patient and the family/caregivers may succeed in diminishing or eliminating driving by the patient (Friedland, 1997; Cortell, et al., 1999). Some states, e.g., Minnesota and Iowa, will also provide advice on the issue. The brochure included with this report may help.

V. Conclusions

1. This information gathered from the questionnaire (40% of the dementia patients in the survey had a firearm in the home, and 44% drove automobiles) can be important in the clinical care of patients with dementia.

2. The project materials (questionnaire, pamphlets, guidelines to providers) were found by the users to be relevant, easy to use, and of value in working with patients/families.
3. Restriction of driving or of firearm possession involves what some consider basic rights, and thus carries a serious ethical obligation on the part of the clinician who recommends such limitations. However, there is an equally serious obligation for clinicians to recommend such restrictions when the patient is known to have cognitive limitations that pose a significant risk when in the possession of a gun or when driving a motor vehicle.
4. Determination of reliable rates of driving and firearm possession among populations of compromised patients requires further carefully structured surveys that include a well-defined denominator population.

VI. Recommendations

1. VHA should disseminate this report widely, to increase awareness of these potential safety issues.
2. The work group products, including questionnaire, informational pamphlets, and guidelines for providers, should be made available for interested sites to pursue further quality improvement and research activity on these topics. Potential mechanisms include posting the materials on the G/EC SHG web site. The appropriate VHA Program Office could also make electronic versions of the materials available for local production on request.
3. The informational pamphlets produced by the work group should be available to patients/families through the appropriate clinic setting after the dementia assessment has been completed. Limited numbers of pamphlets could also be made available in other outpatient settings as appropriate by the VAMC
4. VAMCs should ascertain the rules with respect to dementia, driving and firearm ownership in the states where they are located and provide guidance on these topics to their practitioners.
5. Due to the limited amount of research available on dementia and firearms and dementia and driving, appropriate VHA offices should encourage further investigation of these issues, including formal research. For example, the Office of Patient Care Services could collaborate with relevant VA centers such as Geriatric Research, Education and Clinical Centers (GRECCs), Mental Illness Research, Education and Clinical Centers (MIRECCs), Parkinson's Disease Research, Education and Clinical Centers (PADRECCs), Health Service Research & Development (HSR&D) Centers, or Patient Safety Centers of Inquiry.

6. Further investigation of firearm and driving safety could include examination of different outpatient settings, such as home-based care; or different at-risk populations, such as psychiatric.
7. As part of good clinical practice, VHA should strongly encourage the assessment and appropriate counseling regarding driving practices and availability of firearms in the assessment/management of patients with dementia. The assessment of these issues can be conducted via an interview or with a formal questionnaire.

VII. Comments on the Draft Report and OMI Response

The OMI appreciates the comments from the Acting Deputy Under Secretary for Health, the Deputy Under Secretary for Health for Operations and Management, and Patient Care Services (Geriatric & Extended Care Strategic Health Group and Mental Health Strategic Health Group), and have incorporated them into the report where appropriate.

VIII. Memorandum from the Acting Under Secretary for Health

**Department of
Veterans Affairs**

Memorandum

Date: JUL 26 2004

From: Acting Under Secretary for Health

Subj: Acceptance of Recommendations Contained in the Office of the Medical Inspector's Final Report: Firearm Access and Automobile Driving Among Veterans with Dementia

To: Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)
Office of the Medical Inspector (10MI)

1. This memorandum is to advise your offices that the recommendations in the subject report are accepted as submitted.
2. My decision in this matter is based on consideration of the observations and conclusions of the Office of the Medical Inspector.
3. Please work together to carry out the recommendations found in the report.



Jonathan B. Perlin, MD, PhD, MSHA, FACP

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X. ATTACHMENT A

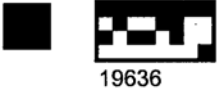
The initial incident

At 10:29 AM on August 3, 2000, the wife of an 83-year-old veteran spoke with a social worker at a VAMC regarding her husband's behavior. She stated she wanted to let the medical center know she went to the magistrate's office to file commitment papers on her husband. The veteran's wife explained that in recent weeks he had been violent, yelling at family members and that this morning, he had pulled a gun on her. Arrangements were made to commit the patient involuntarily to the VAMC.

With a warrant for commitment, a deputy from the local county sheriff's office reported to the veteran's residence at 3:31 PM to transport him to the VAMC. The veteran was wearing baggy khaki pants that were fairly large for a small frame man. (Further police investigation revealed that the deputy did not search the patient for a weapon, even though the patient was reported to have been brandishing a gun in the home.) The patient required assistance via a wheelchair and was also using a portable oxygen tank to compensate for his progressive pulmonary disease. At approximately 4:30 PM, the patient was delivered to the emergency area of the VAMC for evaluation prior to his commitment. At 5:30, the deputy reported the patient was in custody of the VAMC. Shortly thereafter, a physician entered the room to examine the patient. As the physician neared the veteran sitting on the gurney, the veteran pulled a handgun from his pocket and shot the physician in the chest. Other staff assisted the physician to safety and attempted to convince the veteran to put the gun down as they called VAMC police and 911.

Within minutes, two VAMC police officers were on the scene, the veteran, still sitting on the gurney, fired at them. (Police investigation revealed that six of the seven bullets in the veteran's handgun had been fired, so he could have fired as many as five times at the police). The police fired back and inflicted a fatal gunshot wound to the veteran's head. The physician was treated immediately and survived.

XI. ATTACHMENT B



**Office of the Medical Inspector
Firearms and Driving Questionnaire**
(All questions pertain to the patient)



Date: M M / D D / Y Y Y Y
 □ □ / □ □ / □ □ □ □

Age of patient: □ □ □

Gender: ☐ Male ☐ Female

Race (Select only one):

☐ Caucasian ☐ African American ☐ Asian

☐ Other □

Ethnicity:

☐ Hispanic/Latino ☐ Not Hispanic

Please indicate who completed this questionnaire :

☐ Patient ☐ Caregiver (relative) ☐ Caregiver (non-relative)

☐ Other □

FIREARMS

1. Is there a gun or firearm in your home (place where you live)?

☐ No ☐ Yes ☐ Don't Know ☐ Refused

(If subject volunteers that the gun or firearm is kept in a vehicle or on person, mark "Yes")

(If "Yes" then CONTINUE with next question.

If "No" then SKIP to Question 5)

2. Is there ammunition for any of these guns in your home?

☐ No ☐ Yes ☐ Don't Know ☐ Refused

3. Are any of these handguns? (If "No" SKIP to question 4)

☐ No ☐ Yes ☐ Don't Know ☐ Refused

a. Are any of these handguns stored loaded?

☐ No ☐ Yes ☐ Don't Know ☐ Refused

b. Are any of these handguns stored unlocked?

☐ No ☐ Yes ☐ Don't Know ☐ Refused



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4. Are any of these rifles, shotguns or other guns? (If "No" SKIP to question 5)

☐ No ☐ Yes ☐ Don't Know ☐ Refused

a. Are any of these other guns stored loaded?

☐ No ☐ Yes ☐ Don't Know ☐ Refused

b. Are any of these other guns stored unlocked?

☐ No ☐ Yes ☐ Don't Know ☐ Refused

DRIVING

5. Do you drive?

☐ No - Do not complete the remaining questions
☐ Yes - Continue to next question

6. On average, how many miles per week do you drive?

--	--	--

7. Do you drive alone?

☐ Yes ☐ No

8. Have you gotten lost while driving on familiar routes?

☐ Yes ☐ No

9. Do you have difficulty in making decisions in traffic, for instance, when to enter traffic?

☐ Yes ☐ No

10. Have you been involved in any motor vehicle crashes in the past year?

☐ Yes ☐ No - Go to Question 11

a. If "Yes", how many?

--	--

b. If "Yes", were you considered at fault?

☐ Yes ☐ No

11. Have you been advised to limit or quit driving?

☐ Yes ☐ No

12. Have your family, friends, or health care team expressed concern about your driving?

☐ Yes ☐ No

If "Yes" please specify in space below (Please PRINT):

--

This is the end of the questionnaire
Thank you for your assistance



--	--	--

For Staff Use

Site ID

--	--	--

1. Cognitive Status (Mark any that apply, use most recent score within 3 months):

Blessed Score

--	--

MMSE Score

--	--

Mattis Score

--	--	--

CDR Score: .

(Name of Instrument)

Other Score

[illegible]

2. Were the results of this survey reviewed with the (mark all that apply):

Patient ☐ Yes ☐ No

Family / Caregiver ☐ Yes ☐ No

Please return this attachment with the survey form. Do not staple to the survey form

XII. ATTACHMENT C

Information in the Firearms and Dementia Pamphlet

FIREARMS and DEMENTIA

This information is provided as a service by:

Department of Veterans Affairs
Office of the Medical Inspector &
Geriatrics and Extended Care Strategic Healthcare Group

Firearms and Dementia

The presence of firearms in households has been linked to increased risk of injury or death for everyone in or around the home, usually as an impulsive act during some disagreement. This danger is increased when one of the persons in the household has dementia.

What is Dementia?

Dementia is an illness that affects the brain, impairing memory, thinking, and actions. It is usually a progressive illness, and although it is more common in older adults, people of any age can develop it.

Suicide

Firearms in the home can increase the possibility of completing suicide. Coping with painful life events such as the death of a loved one, physical or mental illness, social isolation and loneliness can lead to suicidal wishes. The availability of a firearm offers a highly lethal means of completing suicide. The risk for suicide is also increased in people suffering from depression, which is very common in persons with dementia.

Family Roles

Family members do not always take appropriate action to unload, secure, or remove firearms in the home. These actions should be taken regardless of the severity of dementia or whether your loved one is suffering from a behavioral problem or depression. You are encouraged to be active in helping with your family member's medical problems and also to ask for help and advice about the removal or safe storage of firearms.

Many people see guns as a means of self-protection rather than as a potential safety hazard. The belief in the right to "bear arms" can also be very high. Like driving a car, gun ownership is a powerful symbol of freedom and independence. Although dementia compromises a person's capacity to handle a weapon safely, it is not uncommon for

family members to be reluctant to take away this symbol of independence from people they love.

Simple steps that can save someone you love.

The best way to reduce gun risks is to remove the gun from your home.

If you keep a gun:

- Keep your guns in a sturdy locked cabinet that does not have glass.
- Always store guns unloaded.
- Install trigger guards on all guns to prevent them from being used.
- Keep all ammunition in a locked fireproof safe in a separate place from the guns.
- Keep the keys for the trigger guards, gun cabinet, and ammunition hidden from children and persons with dementia.

The safest action is to get rid of the guns. Store them at a neighbor's house, sell them, or take them to the police to be destroyed. If you keep guns in a home where someone with dementia lives, the lives you risk may be your own as well as other family and friends.

If you have questions regarding gun safety, please see your care provider.

Department of Veterans Affairs
Office of the Medical Inspector
810 Vermont Ave NW
Washington, DC 20420

XIII. ATTACHMENT D

Information in the Driving and Dementia Pamphlet

DRIVING and DEMENTIA

This information is provided as a service by:
Department of Veterans Affairs
Office of the Medical Inspector &
Geriatrics and Extended Care Strategic Healthcare Group
810 Vermont Ave NW
Washington, DC 20420

The family of a person diagnosed with dementia must act upon many issues: medical, legal, financial, and social. Of all these, driving is the one that must be confronted most immediately. The dementia patient operating an automobile may put him or herself and others at risk.

This guide helps persons with dementia and their families as they consider safety and driving risk. It provides suggestions for monitoring, limiting, and stopping driving.

While medical care can help manage dementia, it cannot cure it, and eventually individuals with the disease must stop driving. However, there is no easy answer as to when this decision must be made.

Difficulties

American life is built around the car: distances between home, work, shopping, and school are measured in miles, not blocks. More than just getting around, driving has an emotional component. It represents competence, independence, and freedom: drivers have choices that nondriver's lack. Drivers with dementia often change their driving patterns, driving only during daylight hours, for instance, or driving only on familiar routes to keep using their cars as long as they can. It is hard to quit driving, but quitting is something they and their families must consider sooner or later.

Warning Signs

Getting lost in familiar places
Near misses
Moving violations or warnings
Crashes
Confusing brake and gas pedals
Incorrect signaling
Trouble making turns

Driving in a wrong lane
Confusion at exits
Parking poorly
Hitting curbs
Driving too slow or too fast
Reacting slowly
Not seeing danger early enough
Being angry while driving
Not obeying traffic signs

It is important for family members to pay attention to these driving behaviors and take the wheel if necessary. If the warning signs persist on other trips, the family should discuss the dangers with the driver, other relatives, and the health care team to decide whether further monitoring, limiting the driving, or giving the car up entirely is appropriate.

Easing the Transition

It is best to start such discussions early in the disease before any warning signs appear. This allows the person with dementia to participate fully in the plans before the disease makes such participation difficult, and it allows the whole family to look into transportation alternatives and become comfortable using them while it is still a choice and not a necessity.

Short-term counseling can help some mildly impaired persons understand their driving problems as well as helping them cope with their very real sense of loss.

As the disease progresses, many persons actively resist making changes. They may require more direct approaches. Meeting with respected figures such as doctors, lawyers, or police officers can help. Written instructions may be necessary to reinforce the message that the driver should not drive.

Some drivers with dementia absolutely refuse to give up their cars. For their own safety, they may require active intervention to prevent them from driving, including hiding the keys, disabling or hiding the car, or selling the car itself.

Resources for Assessing Skills

State Motor Vehicle Departments can review a person's ability to drive. Family members can trigger a reevaluation by the state licensing office.

VA Medical Centers often have staff available to evaluate skills of a driver with dementia. Ask your primary care provider to request a screening.

Community organizations in your area may offer a driving skills evaluation program. Check with the Association of Driver Rehabilitation Specialists. 1-800-290-2344 There is usually a fee for this service.

Identification Cards

All states provide identification cards to non-drivers. These are similar to a driver's license and can be used for identification purposes.

Families and friends are often willing to assist with transportation needs, if asked.

Specialized transportation targets groups such as the disabled or elderly. Such services can provide the supervision and personal assistance often required by persons later in the disease. Check with the Area Agency on Aging for assistance at 1-800-677-1116.

Public transportation, including city buses, taxis, and specialized vans, may be an option for those with mild dementia. For most older and disabled people there are special fares that make this an attractive option.

Department of Veterans Affairs
Office of the Medical Inspector

XIV. ATTACHMENT E

Information in the Guidelines for Providers Pamphlet

What constitutes a concern?

- Level of cognitive impairment (i.e. MMSE 8 versus 20)
- Guns stored loaded or unlocked
- Driving problems in the last year

What indicates a need for immediate action and what is the appropriate action?

- If the person is in possession of a gun: call the VA police
- Marked impairment clearly indicating inability to drive safely in a patient who drove in alone: i.e., Blindness, severe physical impairment, significant confusion
- Rapidly assess need for in-patient versus out-patient evaluation
- If in-patient evaluation indicated then admit, Otherwise refer to appropriate sources for further indicated evaluations AND Refer to the Social Worker to obtain alternative transportation home

Further risk assessment

- When you identify a significant problem, refer to the appropriate source for further evaluation.
- Evaluate for depression and aggression in persons who have guns and in patients who are giving up driving.

Discussing the problem with the patient and family

- The patient must give consent to include others in this discussion if he/she has decision-making capacity. If he/she does not have decision-making capacity, safety issues must be discussed with the appropriate surrogate decision maker.
- Review the educational pamphlet and develop an action plan with the patient and/or the surrogate.

Where to refer Driving Evaluations:

- Within the VA: OT, KT or other PMRS driving-skill evaluation programs
- Private sources: such as the Association for Driver Rehabilitation Specialists, American Occupational Therapy Association, or other locally recognized driving assessment programs.

- State Department of Motor Vehicles
- Depression, aggression: Mental Health (e.g., Psychology/Neuropsychology, Psychiatry)

Issues of confidentiality

- The patient must give consent to include others in this discussion if he/she has decision-making capacity. If he/she does not have decision-making capacity, safety concerns must be discussed with the appropriate surrogate decision maker.

Are you required to report this?

- Check with your Privacy Officer who is the Chief of Health Information Management. Regulations vary from state to state. Specific procedures for ROI must be followed.

Obtaining local resources for assistance after loss of driving

- Check with the Area Agency on Aging, Alzheimer's Association
- Refer to the Mental Health as needed

Documentation

In CPRS progress notes, the provider must document the assessments and discussions of safety issues, including use of educational materials. Your assessment of the decision-making capacity of the patient must be included.

XV. ATTACHMENT F

Feedback Form

OFFICE OF THE MEDICAL INSPECTOR DEMENTIA SAFETY PROJECT BETA TEST SITE FEEDBACK FORM

Date: _____ Facility location: _____
Type of clinic: _____ Dementia Clinic _____ GEM Clinic
Contact person name/E-mail/phone: _____

Instructions: Please complete one feedback form for each clinic that participated and return via e-mail to Dr. Susan Cooley (on Outlook as Susan G. Cooley; susan.cooley@hq.med.va.gov) by **November 22, 2002**. For items with numerical scales, please mark with an "X" next to the number that best reflects your opinion. Thank you very much for your site's feedback!

FIREARMS AND DRIVING QUESTIONNAIRE

1. How did you administer the questionnaire? (*Check method used. If more than one method, estimate what percent of time you used each.*)
____ Staff gave questionnaire to either patient or caregiver alone.
____ Staff gave questionnaire to both patient and caregiver, separately.
____ Staff gave questionnaire to both patient and caregiver, together.
____ Patient or caregiver completed questionnaire on his or her own (no staff involved).
____ Other (*specify*) _____
2. How easy was it to use the questionnaire?

1	2	3	4	5
<i>Not easy</i>				<i>Very easy</i>
3. Please describe any specific problems using the questionnaire (identify which section of the questionnaire, i.e., section on demographics, Firearms, Driving, or For Staff Use):

4. How relevant was the questionnaire content?

1 2 3 4 5
Not relevant *Very relevant*

5. Was enough information collected on the questionnaire?

1 2 3 4 5
Not enough *Enough*

6. If relevant, important information were not collected on the questionnaire, what other information would you like to have collected?

7. To what degree do you believe that this questionnaire will be of value in your work with veterans and their families?

1 2 3 4 5
Not valuable *Very valuable*

8. Please describe your overall reaction to the questionnaire. Can you offer any recommendations for improving the questionnaire (e.g., best way to administer; changes in format or content)?

FIREARMS & DEMENTIA PAMPHLET

1. How did you distribute the Firearms & Dementia pamphlet? (*Check one*)

____ Staff gave pamphlet only to patient/caregiver who indicated there is a gun in the home.

____ Staff gave pamphlet to all patients/caregivers who completed the Firearms and Driving questionnaire.

____ Other (*specify*) _____

2. How relevant was the Firearms & Dementia pamphlet content?

1 2 3 4 5
Not relevant *Very relevant*

3. How accurate was the Firearms & Dementia pamphlet content?

1 2 3 4 5
Not accurate *Very accurate*

- ## **DRIVING & DEMENTIA PAMPHLET**

- 30

6. To what degree do you believe providing this information will be of value in your work with veterans and their families?

1

2

3

4

5

Not valuable

Very valuable

7. Please describe your overall reaction to the Driving & Dementia pamphlet. Can you offer any recommendations for improving the Driving & Dementia pamphlet (e.g., best way to distribute; changes in format or content)?

GUIDELINES FOR PROVIDERS

- ### 1. How relevant were the Guidelines for Providers?

1

2

3

4

5

Not relevant

Very relevant

- ## 2. How accurate were the Guidelines for Providers?

1

2

3

4

5

Not accurate

Very accurate

- ### 3. Was enough information provided in the Guidelines for Providers?

1

2

3

4

5

Not enough

Enough

4. If relevant, important information were not provided in the Guidelines for Providers, what other information would you like to have?

5. To what degree do you believe that the Guidelines for Providers will be of value in your work with veterans and their families?

1

2

3

4

5

Not valuable

Very valuable

6. Please describe your overall reaction to the Guidelines for Providers. Can you offer any recommendations for improving the Guidelines for Providers (e.g., best way to use them; changes in format or content)?

XVI. ATTACHMENT G

Table 1
Distribution of Patients by 4 MMSE Groups

	MMSE Groups				
	Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	Total
Frequency	26	71	106	104	307
Percent	8.5	23.1	34.5	33.9	100.0
Cumulative Percent	8.5	31.6	66.1	100.0	

Table 2
Firearm Availability in Home, by 4 MMSE Groups

			MMSE				Total
			Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	
Count	Firearm in home?	No	21	45	66	50	182
		Yes	5	26	40	51	122
		Don't Know	0	0	0	1	1
		Refused	0	0	0	1	1
	Total		26	71	106	103	306
% within Firearm in home?	Firearm in home?	No	11.5%	24.7%	36.3%	27.5%	100.0%
		Yes	4.1%	21.3%	32.8%	41.8%	100.0%
		Don't Know	.0%	.0%	.0%	100.0%	100.0%
		Refused	.0%	.0%	.0%	100.0%	100.0%
	Total		8.5%	23.2%	34.6%	33.7%	100.0%

Table 3

Ammunition Stored in Home, by 4 MMSE Groups

			MMSE				Total
			Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	
Count	Ammunition in home?	No	2	11	11	6	30
		Yes	4	18	28	44	94
		Don't Know	0	2	2	2	6
		Refused	0	0	1	0	1
	Total		6	31	42	52	131
% within Ammunition in home?	Ammunition in home?	No	6.7%	36.7%	36.7%	20.0%	100.0%
		Yes	4.3%	19.1%	29.8%	46.8%	100.0%
		Don't Know	.0%	33.3%	33.3%	33.3%	100.0%
		Refused	.0%	.0%	100.0%	.0%	100.0%
	Total		4.6%	23.7%	32.1%	39.7%	100.0%

Table 4

Handguns or Other Guns Stored Loaded or Unloaded, by 4 MMSE Groups
Among Respondents with Firearms at Residence

			MMSE				Total
			Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	
Count	Handguns or other guns stored loaded?	Stored Unloaded	3	18	30	37	88
		Stored Loaded	1	5	7	12	25
		Don't Know	1	3	2	1	7
		Total	5	26	39	50	120
% within Handguns or other guns stored loaded?	Handguns or other guns stored loaded?	Stored Unloaded	3.4%	20.5%	34.1%	42.0%	100.0%
		Stored Loaded	4.0%	20.0%	28.0%	48.0%	100.0%
		Don't Know	14.3%	42.9%	28.6%	14.3%	100.0%
		Total	4.2%	21.7%	32.5%	41.7%	100.0%
% within mmse4c	Handguns or other guns stored loaded?	Stored Unloaded	60.0%	69.2%	76.9%	74.0%	73.3%
		Stored Loaded	20.0%	19.2%	17.9%	24.0%	20.8%
		Don't Know	20.0%	11.5%	5.1%	2.0%	5.8%
		Total	100.0%	100.0%	100.0%	100.0%	100.0%

Table 5

Handguns or Other Guns Stored Unlocked, by MMSE Groups
Among Respondents with Firearms at Residence

			MMSE				Total
			Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	
Count	Handguns or other guns stored unlocked?	Stored Locked	0	11	15	18	44
		Stored Unlocked	5	15	23	31	74
		Don't Know	0	0	2	1	3
	Total		5	26	40	50	121
% within Handguns or other guns stored unlocked?	Handguns or other guns stored unlocked?	Stored Locked	.0%	25.0%	34.1%	40.9%	100.0%
		Stored Unlocked	6.8%	20.3%	31.1%	41.9%	100.0%
		Don't Know	.0%	.0%	66.7%	33.3%	100.0%
	Total		4.1%	21.5%	33.1%	41.3%	100.0%
% within mmse4c	Handguns or other guns stored unlocked?	Stored Locked	.0%	42.3%	37.5%	36.0%	36.4%
		Stored Unlocked	100.0%	57.7%	57.5%	62.0%	61.2%
		Don't Know	.0%	.0%	5.0%	2.0%	2.5%
	Total		100.0%	100.0%	100.0%	100.0%	100.0%

Table 6

Handguns or Other Guns Stored Locked / Unlocked and Loaded / Unloaded, by 4 MMSE Groups
Among Respondents with Firearms at Residence

Handguns or other guns stored loaded?				MMSE				Total
				Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	
Count	Stored Unloaded	Handguns or other guns stored unlocked?	Stored Locked	0	8	12	14	34
			Stored Unlocked	3	10	18	23	54
		Total		3	18	30	37	88
	Stored Loaded	Handguns or other guns stored unlocked?	Stored Locked	0	1	2	4	7
			Stored Unlocked	1	4	5	8	18
		Total		1	5	7	12	25
	Don't Know	Handguns or other guns stored unlocked?	Stored Locked	0	2	0	0	2
			Stored Unlocked	1	1	0	0	2
			Don't Know	0	0	2	1	3
			Total	1	3	2	1	7
% within Handguns or other guns stored unlocked?	Stored Unloaded	Handguns or other guns stored unlocked?	Stored Locked	.0%	23.5%	35.3%	41.2%	100.0%
			Stored Unlocked	5.6%	18.5%	33.3%	42.6%	100.0%
		Total		3.4%	20.5%	34.1%	42.0%	100.0%
	Stored Loaded	Handguns or other guns stored unlocked?	Stored Locked	.0%	14.3%	28.6%	57.1%	100.0%
			Stored Unlocked	5.6%	22.2%	27.8%	44.4%	100.0%
		Total		4.0%	20.0%	28.0%	48.0%	100.0%
	Don't Know	Handguns or other guns stored unlocked?	Stored Locked	.0%	100.0%	.0%	.0%	100.0%
			Stored Unlocked	50.0%	50.0%	.0%	.0%	100.0%
			Don't Know	.0%	.0%	66.7%	33.3%	100.0%
			Total	14.3%	42.9%	28.6%	14.3%	100.0%

Table 7

Do you Drive, by 4 MMSE Groups

			MMSE				Total
			Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	
Count	Do you drive?	No	26	49	62	34	171
		Yes	0	22	44	70	136
	Total		26	71	106	104	307
% within	Do you drive?	No	15.2%	28.7%	36.3%	19.9%	100.0%
		Yes	.0%	16.2%	32.4%	51.5%	100.0%
	Total		8.5%	23.1%	34.5%	33.9%	100.0%

Table 8

Do you Drive Alone, by 4 MMSE Groups

			MMSE				Total
			Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	
Count	Do you drive alone?	Yes	1	16	31	63	111
		No	0	5	14	6	25
	Total		1	21	45	69	136
% within	Do you drive alone?	Yes	.9%	14.4%	27.9%	56.8%	100.0%
		No	.0%	20.0%	56.0%	24.0%	100.0%
	Total		.7%	15.4%	33.1%	50.7%	100.0%

Table 9

Have you Gotten Lost on Familiar Routes, by 4 MMSE Groups

			MMSE				Total
			Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	
Count	Gotten lost on familiar routes?	Yes	0	3	4	9	16
		No	1	17	39	59	116
	Total		1	20	43	68	132
% within	Gotten lost on familiar routes?	Yes	.0%	18.8%	25.0%	56.3%	100%
		No	.9%	14.7%	33.6%	50.9%	100%
	Total		.8%	15.2%	32.6%	51.5%	100%

Table 10

Do you Have Difficulty in Making Decisions in Traffic, by 4 MMSE Groups

			MMSE				Total
			Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	
Count	Difficulty in making decisions in traffic?	Yes	0	6	5	10	21
		No	1	15	36	57	109
	Total		1	21	41	67	130
% within Difficulty in making decisions in traffic?	Difficulty in making decisions in traffic?	Yes	.0%	28.6%	23.8%	47.6%	100%
		No	.9%	13.8%	33.0%	52.3%	100%
	Total		.8%	16.2%	31.5%	51.5%	100%

Table 11

Have you Been Involved in Motor vehicle Crashes, by 4 MMSE Groups

			MMSE				Total
			Chronic Severe (0-12)	Moderate (13-19)	Mild (20-24)	Normal (25-30)	
Count	Involved in motor vehicle crashes?	Yes	0	1	4	4	9
		No	2	20	39	65	126
	Total		2	21	43	69	135
% within Involved in motor vehicle crashes?	Involved in motor vehicle crashes?	Yes	.0%	11.1%	44.4%	44.4%	100.0%
		No	1.6%	15.9%	31.0%	51.6%	100.0%
	Total		1.5%	15.6%	31.9%	51.1%	100.0%